NJ DIVISION OF DISABILITY DETERMINATION SERVICES
ACTIVITIES OF DAILY LIVING QUESTIONNAIRE

CLAIMANT'S NAME: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER.: _____

If you need additional space for an answer, please use the back of the form and note the item number, for example, IIA.

I. GENERAL INFORMATION

A. Do you live alone or with others? If you do not live alone, with whom do you live?

_____

_____

B. Please describe how you spend a typical day.

_____

_____

_____

_____

_____

_____

_____

_____

_____

II. ACTIVITIES

PLEASE DESCRIBE HOW YOU FUNCTION IN EACH OF THE FOLLOWING AREAS AND HOW OFTEN YOU PERFORM EACH ACTIVITY. IF YOU NEED HELP, WHAT KIND OF HELP DO YOU NEED AND WHO HELPS YOU?

A. SHOPPING _____

_____

_____

_____

B. PREPARING MEALS (cooking, using kitchen appliances, etc.) _____

_____

_____

_____

_____

C. HOUSEHOLD MAINTENANCE (cleaning, taking out garbage, vacuuming, washing dishes, doing household repairs, gardening, etc.) _____

_____

_____

_____

_____

D. MONEY MANAGEMENT (paying bills, rent, checking account, etc.) _____

_____

_____

_____

_____

E. TRANSPORTATION (driving, taking public transportation, able to travel alone?) _____

_____

_____

_____

_____

F. SOCIAL/RECREATIONAL ACTIVITIES (reading, watching TV, hobbies, clubs, visiting friends and relatives, religious activities, etc.) _____

_____

_____

_____

III. A. Do your illnesses, injuries, or conditions affect your walking? [ ]Yes [ ] No
If yes, answer questions 1 and 2.

1. How far can you walk before you have to stop and rest? _____

2. How long do you rest before you can continue walking? _____

B. Do your illnesses, injuries, or conditions affect the use of your arms or hands? [ ] Yes [ ] No

If yes, explain how your illnesses, injuries, or conditions affect any of the following: Lifting, reaching, using your hands.

_____

_____

_____

_____

IV. A. Are you supposed to take medication for your illness? [ ] Yes [ ] No

B. If yes, do you take your medication regularly? [ ] Yes [ ] No

a. If you answered YES to A or B, note what kind of medication and who prescribed it (name and telephone number of doctor or clinic).

_____

_____

_____

_____

V. PLEASE GIVE US NAMES OF TWO PEOPLE WE MIGHT CONTACT IF WE NEED MORE INFORMATION ABOUT YOUR DAY-TO-DAY LIFE:

Name	Relationship	Address	Telephone

_____

_____

_____

_____

VI. USE THIS SPACE TO TELL US ANY OTHER THINGS WE SHOULD KNOW ABOUT YOUR CONDITION. _____

_____

_____

_____

_____

_____

DID ANYONE HELP YOU FILL OUT THIS FORM? [ ] Yes [ ] No
If yes, please explain how.

_____

_____

_____

THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____
(Signature) **(Date)**